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An interview with Dean Vafiadis, DDS

“A.S.A.P. Polishers save chair time by quickly polishing porcelain and composite restorations in less than a minute.”

- Danièle Larose, DMD, AAACD

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Dentistry and photography courtesy of Danièle Larose, DMD, AAACD
This past May, I had the opportunity to attend a Class of 2023 dental school graduation. As the 100+ students and their families, friends, faculty, and mentors gathered for a few hours to celebrate and be recognized for their tremendous achievements, I couldn’t help but reflect on how hard these new dentists had worked over their four years of advanced higher education and training to become the next generation of clinicians to enter the profession of dentistry. To think that 6,600 graduates have recently entered communities across North America to treat patients somehow seemed quite remarkable at the time.

After speaking to several graduates, they expressed that even after graduation their learning journey was not over. Most were going on to residency programs, a significant number were pursuing specialty training across the U.S., and more than a few of them were going on to practice in the clinics where they watched their parents and mentors practice.

The keynote speaker for the convocation shared many insights for the grads to reflect on; there was also commentary on the support they received from family, faculty, and peers. The 3-hour ceremony was filled with so many big smiles, truly aligning with the profession that these graduates had signed up for. Most of you reading this, more than likely, rarely reflect back on your dental school graduation day. That being said, it has become more and more evident that in this profession, mentorship, continual learning, resource networks, CE communities, and local study clubs are becoming increasingly important – allowing for support and guidance for this next generation of dental professionals.

The underlying message is evident, as dental professionals, you are lifelong learners, most likely starting well before dental school, and in continual pursuit of updating your knowledge, improving skills and processes, and ultimately delivering the best possible clinical outcomes for your patients. You are also a group of individuals who are, more often than not, always willing to help one another with information sharing, guidance, and support with the clinical challenges you face on a daily basis. Our team at Clinician’s Choice is proud to be part of your network, focused on delivering innovative product solutions supported by education and technique guidance in order to assist you in overcoming these daily challenges.

Congratulations to all of the new graduates, what a milestone achievement! Thank you to all of those who will go on to mentor, challenge and support this new, dynamic cohort of dental professionals.

Brian S. Allen
President
Clinician’s Choice
Patient Management and Treatment of the Midline Diastema

A treatment plan is likely to be accepted by a patient if there is, at a minimum, a faith in the dentist that the restorative result will reflect the patient’s desired outcome at the agreed upon cost and timeline. This is especially true with a new patient with whom there is little or no shared dental experience. Any treatment plan requires a thorough investigation and assessment of clinical findings and is necessary to present treatment options and promote the patient’s understanding and ownership of their existing dental condition and its impact on the restorative result. There is a burden of responsibility to collect as much information from the patient as it relates to all aspects of treatment. However, this responsibility does not end with the clinical examination of hard and soft tissues, radiographs, photos, models, and medical history. Taking time to establish a rapport, delving into past dental experiences, and attempting to assess their potential as partners in the restorative process is essential to mitigate any challenges once treatment begins. Trust in the clinician can build as the case progresses, allowing the patient to “keep the faith”, as the patient’s ongoing engagement and cooperation can be critical to obtaining the desired clinical result.

Such was the case when a young woman presented as a new patient seeking options to improve the appearance of her “flat front teeth”. (FIG. 1)

A comprehensive clinical examination revealed advanced incisal wear on teeth #6-11, a constricted bite, fixed wire retention on teeth #7-10 and #22-27 along with failing and unaesthetic composite restorations in the posterior and anterior dentition. The treatment plan presented, and accepted, involved the correction of the restricted bite and establishing a more harmonious occlusion through Invisalign (Align Technology) orthodontics, along with the replacement of the posterior composites. Lengthening of the central incisors to address the incisal wear would be undertaken only after this was achieved. This treatment plan was complicated through the necessity of removing the fixed lingual retentive wires prior to the aligner therapy as it was anticipated that the removal of this fixed retention and orthodontic movement would result in the re-appearance of the patient’s natural midline diastema. This added the necessity of closing the diastema in addition to lengthening the central incisors. While this was foreseen and the patient was informed of the possibility of the diastema reforming, she nonetheless presented for an orthodontic recall appointment visibly frustrated and agitated. Her heightened level of anxiety was due to the amount of time involved for Invisalign therapy and questioning the ultimate esthetic outcome of her treatment. Her fear stemmed from the presence of the diastema and that longer, wider central incisors may take on a “Bugs Bunny” appearance. The patient was subsequently calmed and faith was restored that treatment was progressing as anticipated, agreeing to continue with the aligner therapy.

Once the orthodontic goal of the treatment plan was achieved, the restorative phase entailed the closure of the midline diastema and lengthening and recontouring of teeth #8 and 9. Itero (Align technology) scans of the maxillary and mandibular arches (FIG. 2A, 2B) were obtained from which diagnostic models were fabricated.

A young woman presented for treatment options to “fix her flat front teeth”. The accepted treatment plan involved short-term aligner therapy followed by a midline diastema closure and lengthening of the maxillary central incisors.

FIG. 1
Scans of the mandibular and maxillary arches were obtained. Models were made from these and mounted. Wax-ups of the ideal restorative result were then fabricated on these mounted models.

FIG. 2B
A wax-up of the ideal incisal length of the maxillary central incisors was fabricated on the mounted models. The wax-up provided the ideal incisal length and thickness, facial and lingual contours, and occlusal

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Dr. Dimple Desai is the founder of Luminous Smiles of Newport Beach, a boutique dental practice focusing on rejuvenating patients’ lives through their smiles. She is one of the 350 Accredited Members of the American Academy of Cosmetic Dentistry in the world. Dr. Desai has been recognized locally as Orange County’s Top Dentist for the past four years and was selected as one of the Top 40 Dentists under the age of 40 in the country. Dr. Desai has been featured in various dental publications and continues to dedicate her passion to advancing her career in Dentistry. Dr. Desai is also a graduate of the Kois Institute and obtained both her Bachelor’s degree in Dental Hygiene and a Doctorate of Dental Surgery from the University of Southern California. She later returned to her Alma Mater as a Clinical Adjunct Professor to educate dental students on the clinic floor.
contacts of teeth #8 and 9. However, until the re-emerging diastema has stabilized, the width of these teeth would be difficult to be determined. A lingual matrix was fabricated utilizing the diagnostic wax-up by extruding Template Ultra Quick Matrix Material (Clinician’s Choice) along the anterior lingual surface of maxillary model, up to and including the facio-incisal line angle of the anterior teeth. While primarily used for the fabrication of a provisional matrix, the accuracy of Template is ideal for capturing the optimal lingual contours and incisal edges of teeth #8 and 9 established in the wax-up. The lingual matrix was replaced intra-orally in order to check the accuracy of its fit. (FIG. 3) A line corresponding to the incisal extent of the prepared teeth was scored onto the lingual matrix using a sharp explorer. The lingual matrix was then set aside.

The patient was anesthetized due to the removal of existing composite as well as the possibility of wedge placement during the finishing stage. Shade selection was achieved by placing small round samples of possible composite shades onto the facial surface of teeth #8 and 9. These were light-cured and a black and white photo of the selected shade was taken to confirm the correct value of the shade. Evanesce composite (Clinician’s Choice) was selected for this case because of its handling qualities, specifically its smoothness in spreading across the tooth surface, its ability to easily blend into the surrounding tooth structure, its polishability, and the absence of air bubbles. An Optragate Retractor (Ivoclar) provided a clear, wide field that allows context for consistency in restoration shape, inclination and emergence profile with the adjacent teeth. Existing composite restorations were removed from the mesial surfaces of teeth #8 and 9 using a F8888 fine diamond bur (Brasseler) at high speed while establishing a starburst bevel on the facial surfaces. (FIG. 4) A coarse Contours Finishing and Polishing Disc (Clinician’s Choice) was used to smooth out any sharp edges or points. Finally, a PrepStart (Danville) air abraded the prepared surface to remove any enamel and composite debris and enhance overall adhesion. (FIG. 5)

Mylar strips isolated teeth #8 and 9 from the adjacent teeth while the facial and lingual surfaces were etched with 35% phosphoric acid for 20 seconds (FIG. 6) then thoroughly rinsed. Adhese Universal (Ivoclar) adhesive was applied to the etched surfaces (FIG. 7), air-thinned and light-cured. The intent was to establish the desired length of the restored teeth first by placing the lingual shelves, then closing the midline diastema before finishing the incisal aspect of the restorations. A thin layer of Evanesce Enamel White (Clinician’s Choice) was placed onto the lingual surface for 20 seconds, then air-thinned and light-cured.

With the incisal length established, restoring the midline diastema could be completed with a more predictable proximal contour. Using a caliper, the widths of the individual central incisors and the total distance from their distal surface to distal surface was measured in order to determine the ideal width of each individual restoration required to close the midline diastema. There are several techniques for diastema closure. In my hands, utilizing the pull-through technique with a mylar strip provides the most control of proximal contact development and initial emergence profile. It is essential to use a composite for this technique that has enhanced handling characteristics in addition to being highly esthetic in order to be easily manipulated into place and disappear into the surrounding tooth structure. This technique was used on tooth #9 using a single layer of Evanesce A1U composite (Clinician’s Choice). The Evanesce A1U was extruded onto the central area of the preparation and spread into place. An REJ #4 composite instrument and the Composite Ninja (Clinician’s Choice) easily sculpted and shaped the composite interproximally, limited by the mylar strip. (FIG. 9) The pull-through technique was used at this point to create a
uniform proximal surface and contact while maintaining an overhang-free emergence profile. A #3 composite brush with ResinBlend LV smoothed and blended the Evanesce A1U into the facial tooth structure after the pull-through, producing a surface that required minimal finishing. The restoration was light-cured from the facial and lingual. The identical sequence of Evanesce A1U composite placement was repeated on tooth #8. (FIG. 10)

By utilizing the pull-through technique and creating the desired contours and surface smoothness prior to polymerizing, it was possible to immediately proceed to completing the incisal portion of the restorations. The relative translucency of the Evanesce Enamel White was not sufficient to replicate the existing incisal translucency of the adjacent teeth; therefore, a grey tint was added in this area. A thin increment of Evanesce A1U was placed over the Enamel White layer and light-cured. A small amount of grey tint was placed onto the A1U of both teeth #8 and 9 with a CompoSculpt #1/2 (Hu-Friedy). Any excess tint was blotted using a microbrush. Once this application of tint was light-cured and assessed, the final layer of Evanesce A1U was placed over this and adapted to the facial surface of each tooth. Once again, a #3 composite brush lightly coated with ResinBlend LV was used to smooth and blend the A1U over the tooth surface and composite from the diastema closure.

If a well-organized approach to the restorative phase is followed, there is need for minimal finishing prior to polishing. A wax-up on mounted models

This patient did not display any significant facial lobes, depressions or surface texture. Should this have been necessary to establish, a F8888 (Brasseler) fine flame-shaped diamond is ideal. A sweeping motion at low speed is effective for texturizing the smooth surface as well as developing lobes prior to polishing.

A.S.A.P. Polishers (Clinician’s Choice) were used to obtain a high luster that was present on the adjacent teeth. The purple Pre-polisher initiated that reflects the desired restorative result and accurately transferring this information directly to the preparation ensures that the lingual contours and incisal edge location and thickness are already established. Taking the time to place, shape and blend the remaining composite prior to light-curing can limit the need for further adjustments. Regardless of the amount of finishing anticipated, a methodical finishing protocol keeps this step predictable and time efficient.

In this case, the finishing protocol involved the placement of a wedge prior to adjusting. This initiated tooth separation that would increase the access and accuracy to adjust the emergence profiles later in the protocol. Once the length and inciso-facial line angles were confirmed, the facial planes and proximal line angles were surveyed. The side of a pencil lead was used to outline the proximal line angles on both the restorations and adjacent teeth and compared. A coarse Contours Finishing and Polishing Disc (Clinician’s Choice) was used to correct the proximal line angles to better reflect those on the lateral incisors. (FIG. 11) Axial inclination was assessed through visualizing from various cervical, incisal and proximal angles and adjusted accordingly with the same coarse disc. The sequence of medium, fine and super-fine discs was followed to prepare the restorations for polishing. (FIG. 12)
the polishing sequence. At 10,000 RPMs and moderate pressure, it took approximately 20 seconds to prepare the composite surface for the Final High Shine polisher. Using the same speed but a lighter touch, the peach colored Final Polisher required the same amount of time to complete the polishing sequence. (FIG. 13) While A.S.A.P. Polishers can bring out a very high luster, this was further enhanced using a small amount of Enamelize Aluminum Oxide Polishing Paste on a Final Shine Cotton Polishing Wheel (Clinician’s Choice) with a light touch. (FIG. 14) The resulting restorations on teeth #8 and 9 were met with enthusiastic approval from the young patient. (FIG. 15)

A complex treatment plan that encompasses multiple modalities can result in a lengthy treatment timeline. In this case, the long-term solution to the restoration of a worn anterior dentition to a more natural length and contour could only be addressed after an additional orthodontic phase. Even with a thorough understanding and agreement to the process, this young patient became unsure and disillusioned at a critical point in her treatment. Fortunately, after reviewing the progress that had been made, along with the trust that was built up to that point, restored the confidence to stay the course. It is, therefore, essential to continue to nurture the professional relationship that fosters cooperation and re-affirmation of the success of each step on the path that leads to the anticipated esthetic restorative result. (FIG.16)
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The Starburst Bevel: A Simple Solution for Enhanced Esthetics and Retention

Developing a protocol for your Class IV technique is essential for attaining predictable and long-lasting esthetic restorations. Depending on the size of the Class IV and the presence of incisal translucency and surface characteristics of the adjacent teeth, for instance, your anterior composite protocol should also be both flexible and versatile. Layering of composite materials available in multiple shades and opacities and finishing and polishing techniques to allow you to better adapt your technique is critical to an excellent restorative result. However, it is equally important that you establish a consistent approach to your bevel design. In addition to esthetics, hiding the fracture line and bonding failures are significant challenges in these cases. This makes bevel design a significant consideration in seamlessly blending your restoration into the surrounding tooth structure while providing the highest degree of retention for long term service.

“The starburst design allows light to diffuse and refract in a way that hides the junction between tooth and restoration better than a flat, traditional bevel.”

The term retention has taken on an increasing significance in the dental world. Retention of the restoration has always been a cornerstone of the successful longevity of direct and indirect restorative dentistry. Retention also refers to the ability to retain a patient of record. Failure of a restoration in the esthetic zone is often not tolerated well by the patient due to its social, economic, and degree of inconvenience, and may undermine the confidence a patient has in their dental team. Thanks to a higher dental IQ, the dental public holds higher expectations of restorative quality in both esthetics and life span. The source from which a patient obtains dental information and its esthetic and functional potential is no longer limited to the dental office. Social media and the internet have become popular media through which our patients gain insight into their existing or desired dental treatment possibilities. It is not uncommon for an unhappy patient or one seeking a new dentist to choose a dentist based on positive internet reviews.

This relatively small incisal fracture was best suited for a direct composite and no local anesthetic was necessary. After shade selection, the anterior teeth were isolated using a Comfort View Lip and Cheek retractor (Premier). This provided both the isolation essential for ideal bonding conditions as well as the visibility necessary to mimic the shape, profile, contour and surface characteristics of the adjacent dentition. A starburst bevel was placed using a coarse, flame-shaped diamond bur. (FIG. 2) The

FIG. 1
A young woman presented with a mesio-incisal fracture on tooth #8, previously restored one year earlier.

FIG. 2
A starburst bevel provides a larger surface area to increase the strength and longevity of the bond. In addition, the junction between the restoration and tooth was disguised through enhanced diffusion and refraction of light.

Dr. McMahon owns the largest cosmetic dental practice in Western Pennsylvania. She is accredited by the American Academy of Cosmetic Dentistry, and a Fellow of the prestigious American Society for Dental Aesthetics and a Fellow in the Academy of General Dentistry. An author and lecturer, Dr. McMahon has devoted her professional career to the pursuit of advanced technologies in cosmetic and minimally invasive dentistry. She frequently lectures across the United States on minimally invasive dentistry, technology and conservative cosmetics. She has been voted by her peers as a Top Pittsburgh Dentist every year for over 20 years.

Susan McMahon
DMD, AAACD, FAGD
bevel progressed from being deeper at the fracture line to more superficial and fading into the enamel. In addition to providing more surface area for increased bond strength and retention, the starburst design allows light to diffuse and refract in a way that hides the junction between tooth and restoration better than a flat, traditional bevel.

A kidney bean-shaped metal bicuspid sectional matrix, oriented vertically, was placed between teeth #8 and 9. (FIG. 3) This isolates #8 while the etch and adhesive bond is placed as well as providing a better convex initial proximal contour compared to a mylar strip.

Max Etch (Clinician’s Choice) was placed over the preparation, slightly beyond the starburst bevel, for 15 seconds. Max Etch is a viscous 35% phosphoric acid that holds firm vertically for the duration of the etch. Once the etch is thoroughly rinsed off the tooth, Peak Universal was scrubbed into the enamel and dentin for 20 seconds. Peak Universal is easily applied due to its applicator syringe and brush combination and provides a high strength bond to both enamel and dentin. The air-thinned adhesive was then light-cured using a Valo for 10 seconds. I prefer the Valo X, however it is essential that your choice of curing light has broad-wavelength curing capabilities, a large surface area and a consistent strength, ideally 1000mW/cm², over the entire surface of this area.

Evanesce A1U (Clinician’s Choice) was placed as the final, or body layer. This composite was chosen for its chameleon-like shade blending, and its ability to finish quickly and polish to a super high shine. Once placed and spread onto the tooth with the ARTE spatula, a composite brush lightly wetted with ResinBlend LV (Clinician’s Choice) was used to further blend and smooth the facial layer of composite into the uncut enamel. (FIG. 6) The use of ResinBlend LV produces a very smooth final surface that significantly reduces finishing time. At this point, the restoration was light-cured from the facial and lingual for 10 seconds.

The starburst bevel is the first step in helping the restoration disappear. The next step was the careful placement of a translucent lingual enamel layer using Evanesce Enamel Clear (Clinician’s Choice). I favor a syringe over a compule in the anterior, not only to reduce waste, as you dispense only what is needed, but also to eliminate folds or voids when dispensing the composite. Evanesce ENC was carried to the preparation with a paddle-shaped ARTE spatula (LM-Dental) and adapted to form the lingual layer against a gloved finger. The lingual layer was kept relatively thin, being brought just into the deepest aspect of the bevel. (FIG. 4) At this stage, the ENC was blended into the base of the starburst bevel and was “chopped” using the ARTE spatula to create a variegated appearance and interface with the subsequent layer of composite. The Evanesce ENC was then light-cured for 10 seconds from the facial and 10 seconds from the lingual. This organic interface, compared to one that is flat, allows light to better reflect and absorb in a way that mimics natural tooth structure, helping the restoration disappear. In the case of a larger Class IV, I would build the entire proximal wall against the metal sectional matrix band first then establish the lingual layer using a gloved finger as a lingual matrix. The next layer required a more opaque and brighter composite to hide the tooth-restoration junction. The brightness and higher opacity of Vit-l-escence Opaque Snow is very effective for the purpose of hiding the fracture line. Opaque Snow was adapted onto the preparation using the ARTE spatula and “chopped” into the ridges straddling the translucent lingual layer and the enamel bevel. (FIG. 5) This opaque layer was light-cured for 10 seconds each from the facial and lingual.
Once the metal sectional matrix band was removed, the finishing and polishing protocol started with evaluating the primary anatomy. As this was a relatively small Class IV, the occlusal contacts were quickly checked and adjusted as was the accuracy of the incisal edge placement. Taking the time to smooth and blend the final layer of Evanesce A1U using ResinBlend LV left an ideal restorative surface that was essentially ready for polishing. The only finishing required was the mesial aspect of the restoration that was in direct contact with the metal matrix band. This was adjusted and gently rounded using a coarse Sof-Lex polishing disc (3M) as was the proximal line angle until it lined up with the more cervical aspect of the natural line angle. The adjacent tooth structure displayed some subtle surface texture. This was easily replicated on the restoration using a coarse, round-ended, tapered diamond applied without water and at low RPMs. This was also effective in lobe development in addition to the textured facial surface.

Once the secondary and tertiary anatomy is carefully established, it makes sense to use an effective and efficient polishing system that isn’t aggressive. Therefore, polishing of this Class IV consisted of the spiral Jiffy Finishing and Polishing System. The first polisher was applied with a light touch in a wiping motion at 8-10,000 RPMs for 30 seconds. This polisher prepares the composite surface for the final polisher and although not desirable in this case, is capable of removing small scratches and bur marks. The final polisher was used in a similar manner with a slightly lighter touch for another 30 seconds. Alternatively, I also use the A.S.A.P. 2-step diamond polishing system (Clinician’s Choice) which is also ideal for quickly attaining a high gloss finish while maintaining the desired anatomy and surface texture.

The patient was extremely pleased with the final result. (FIG. 7 and 8) Moreover, the attention paid to blending the composite into the tooth for an invisible restoration also created maximum retention in order for her to avoid another unfortunate negative dental experience.

Each step of your Class IV composite protocol should add confidence and predictability to the desired result. Adopting the starburst bevel to your anterior composite technique increases the potential for improved retention through strengthening of the adhesive bond. The starburst bevel is also exceptional in its ability to optically enhance the esthetic potential of the composite, and performs both of these without adding a step, material or additional instrumentation. It is within our clinical and professional purview, and in our patients’ best interest, to continue to improve and adopt techniques that lead to better clinical results. At least in this case, that can lead to improved retention of both restoration and patient.

![Immediate post-op. Class IV restoration is indistinguishable from the surrounding tooth due to the combination of the starburst bevel design and optimal esthetic properties of Evanesce composite.](FIG. 7)

![Post-operative full-face portrait view.](FIG. 8)
**Description**

*Evanesce™ Universal Restorative* is a nano-enhanced, light-cured, packable and esthetic resin-based composite. It is designed to blend with the surrounding hard tissues, offers high polishability, and can be used for simple and complex restorations. It contains rheological modifiers that provide for its putty-like handling and its ability to adapt to preparations and remain in place. *Evanesce Universal Restorative* is available in enamel (E), universal (U) and dentin (D) shades with 80%, 85% and 90% opacity, respectively, and also in three non-Vita Enamel FX shades. It is delivered in 4 g syringes and pre-loaded 0.3 g single-use tips in shades: A1U, A2U, A3U, A3.5U, A4U*, B0.5U*, B1U, B2U, C1U*, C2U, C3U*, A1E, A2E, A3E*, A3.5E*, B0.5E*, B1E, B2E*, A1D*, A2D, A3D*, A3.5D*, B1D*, C4D*, as well as bleach shades BL1U* and BL3U*. Specialty shades available: Enamel FX Clear, White, and Incisal.

* Available in single use tips only.

**Indication**

- All anterior and posterior direct restorations.

**Unique Features**

- The refractive index of its unique nano pigments and fillers are optimized through a proprietary process.
- Rheological modifiers provide for adaptability during packing and prevent slumping.

**Clinical Tips**

- The dentin and enamel shades in combination look great in the anterior region. It's worth using both of these shades.
- Great for posterior composites.
- Use the universal shade for medium-sized restorations.
- Over-build to contour it.
- Press down with a burnisher along the margins to adapt it.
- Warm it before placement.
- The enamel shade is nice for anteriors, somewhat translucent.

**Evaluation Highlights**

*Evanesce Universal Restorative* was evaluated by 34 consultants, with a total of 677 uses.

- Easy dispensing and manipulation.
- Putty-like, non-sticky consistency.
- Good polishability.
- Blends with tooth structure.
- Esthetic.

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**Consultants’ Comments**

- "Great handling. Easy to dispense, packs very nicely and stacks very well."
- "I liked its putty-like consistency. It doesn’t stick to instruments, pull back or slump."
- "Easy to sculpt, contour, finish and polish."
- "*Evanesce* handles with excellence. The final contour maintains its shape and blends into the natural tooth prior to light curing."
- "Good shade matches and polishability. Universal shades are excellent."
- "Nice polish and blends well. A good finish is achieved quickly."
- "Esthetics is exceptional. Great shade match incisally and very life-like."
- "I liked the opaque shades for masking dark areas and implant crown screw access holes."

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**THE BEST BLENDING COMPOSITE I HAVE EVER USED. IT BLENDS BEAUTIFULLY INTO THE TOOTH.”**

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**Key Features:**

- Excellent
- Very Good
- Good
- Fair
- Poor

- Ease of dispensing
- Ease of placement
- Lack of slumping after placement
- Shade match after curing
- Ease of finishing and polishing
- Quality of final polish
- Versatility for restorative procedures

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**Compared to Competitive Products:**

- 24% Better
- 50% Equivalent
- 28% Worse

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**Percentage of Consultants Who Would:**

- 15% Purchase instead of current product
- 50% Purchase in addition to current product
- 35% Not purchase
Using Affinity Crystal and Evanesce Flow in an Injection Molding Technique

The injection molding technique is gaining popularity for dental clinicians due to its wide array of procedural applications. This technique involves injecting a low viscosity resin composite through a transparent silicone index made from a diagnostic wax-up, aiming to replicate the mock-up.

Having the capability to quickly and predictably transfer a mock-up into a patient’s mouth using composite resin allows clinicians to offer their patients alternative treatment options. This procedure provides an effective way to restore multiple teeth in the arch as temporary, transitional and/or permanent restorations. (FIG. 1)

Then the matrices were prepared by making a small opening, leading from the intaglio surface of the matrices to the outer surface. The access hole was created using a composite syringe tip to puncture the intaglio surface of the matrix and push it through to the outer surface. The location of the holes are incisal/occlusal to the teeth that are to be restored. First, the access holes for the duplicate model were prepared, leading to tooth #’s 21, 23, 25 and 27, as #’s 22, 24 and 26 were deactivated on this model. The second matrix was of the full wax-up, and vent holes were created leading to #’s 22, 24 and 26.

Minimal preparations were done on all teeth, which includes removal of decay, 2mm bevel preparations with a 7901 flame shaped bur (Brasseler) and air abrasion. PTFE tape was placed on #’s 22, 24 and 26. Etching and bonding procedures were done on #’s 21, 23, 25 and 27. The first matrix was placed and the Evanesce Flow Composite (Clinician’s Choice) was injected through the tiny access holes, followed by polymerization of the composite resin through the clear matrix. (FIG. 3) After the first set of teeth were restored, finished with Neodiamond pointed cone bur (ref #3314.10VF) and polished with ceramic polishing wheels: coarse blue (FLW14C), medium pink (FLW14M), and fine gray (FLW14F), the same procedure was done to restore #’s 22, 24 and 26. Finally, the occlusion was adjusted to achieve bilateral simultaneous equal-intensity contacts.

Susan Prater-Kudlats
DMD

Dr. Susan Prater-Kudlats is a general dentist in Jacksonville, Florida with a focus on cosmetic and restorative dentistry, utilizing the latest digital technology. She graduated from the Medical College of Georgia in 2009 and continues to further her education through advanced training courses. She is currently attending the Kois graduate program and is set to graduate May 2024. Dr. Prater-Kudlats also serves as a Key Opinion Leader for Desktop Health, one of the leading dental 3D printing manufacturers. Dr. Prater-Kudlats enjoys sharing her life and love of dentistry via Instagram @dr_seuzz. Her creative social media presence has led to speaking engagements on social media branding for dentists featured by Cerec Doctors (CDOCS), as well as opportunities to promote the products that she believes give her the ability to deliver the best patient care possible.
Stay Ahead of the Pack with The Dental Digest Podcast
Hosted by Dr. Melissa Seibert

The Dental Digest podcast is a clinical dental podcast with a mission of helping dentists stay on the cutting edge of evidence-based dentistry. Host and creator Dr. Melissa Seibert has a passion for following evidence-based dentistry, continuing education, and sharing what she has learned with others.

“It is exceedingly challenging for dental schools to be able to condense all relevant dental information into four years. With the advent of implant dentistry, 3D imaging, digital dentistry, etc., it’s exceedingly difficult for dentists to be able to learn everything in dental school,” states Dr. Seibert. “Oftentimes dentists graduate feeling like they didn’t learn enough in school to even scratch the surface of the knowledge available. What’s more, it’s particularly challenging for dentists to get access to current evidence-based information.”

“Stay Ahead of the Pack with The Dental Digest Podcast
Hosted by Dr. Melissa Seibert

“The purpose of the podcast is to help dentists get access to the best speakers, authors, and educators in real time...This podcast is free and accessible to all.”

Topics such as digital dentistry can be especially challenging to stay up-to-date on because the technology evolves so quickly that what is published in a journal today may no longer be relevant, and oftentimes takes years for a research study to get published and a decade for a textbook to be made available. The podcast is useful for rapidly evolving topics in dentistry because the podcast can publish information on the topic before it becomes obsolete.

The purpose of the podcast is to help dentists get access to the best speakers, authors, and educators in real time. A new episode is published every week. Attending a course or seminar can be cost-prohibitive. Dental Digest podcast is free and accessible to all.

The podcast features a whole range of topics in dentistry, such as implantology, restorative dentistry, oral pathology, esthetic dentistry, dental photography, and much more. It has featured world-class educators such as Frank Spear, Rebecca Bockow, Pascal Magne, Amanda Seay, and more.

The Dental Digest podcast is in the top 1% of all podcasts globally and has won the most educational podcast in dentistry distinction two years in a row from Course Karma. With a 4.9 star rating and over 200 reviews on Apple Podcasts, listeners have been exclaiming, “Amazing resource for dental students!” and “This podcast is like a mentor.” It can be found on all major podcast platforms, such as Apple podcast, Spotify, Audible, iHeart radio, Amazon music, and more.

Visit dentaldigestinstitute.com to learn more, listen, and earn CE credits.
Dr. Nancy Zeis is a general dentist focused on esthetic, digital, and restorative dentistry. She maintains a practice in Edina, Minnesota. Dr. Zeis is a graduate of the University of Minnesota and the Kois Center.

A.S.A.P. Polishers bring out the esthetic potential of my composite restorations in literally one minute or less! A.S.A.P. Polishers are also highly effective on other substrates such as zirconia and lithium disilicate. Their versatility, combined with their ability to be autoclaved up to 30 times means a savings in time, inventory and cost.

Dr. Chan earned his DMD degree in 1989 from Oregon Health Sciences University. He maintains a full-time practice focused on cosmetic and comprehensive dentistry located in Ridgefield, Washington. He is the past President and an Accredited member of the American Academy of Cosmetic Dentistry.

A proper finishing and polishing technique is critical to the longevity of your composite restoration by prevention of staining and the health of the adjacent soft tissue. A.S.A.P. Polishers give direct composite restorations a lifelike polish that virtually emulates the vitality of natural teeth in less than 30 seconds. The flexible polishing spirals are designed for optimal adaptation to any surface, even on difficult-to-reach areas such as interproximal surfaces, without damaging the established anatomy of the restoration. A.S.A.P. Polishers are an integral part of my composite finishing workflow every single time!

A.S.A.P. Polishers bring out the esthetic potential of my composite restorations in literally one minute or less! A.S.A.P. Polishers are also highly effective on other substrates such as zirconia and lithium disilicate. Their versatility, combined with their ability to be autoclaved up to 30 times means a savings in time, inventory and cost.

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A.S.A.P. Polishers are an integral part of my composite finishing workflow every single time!

with
David Chan, DMD, AAACD

with
Nancy Zeis, DDS
**DURABILITY/MINIMAL WEAR**

“Clinicians can increase the longevity of their restorations with proper finishing techniques. A.S.A.P. Polishers not only provide a high gloss luster, they can also reduce plaque accumulation and increase patient comfort. These wheels are especially kind to the gingiva in case of accidental contact.”

with

**Chad Duplantis, DDS, FAGD**

**FAST**

“In our laboratory, we compared the gloss produced by A.S.A.P. Polishers and Enhance/PoGo. Each specimen was polished in 15-second increments for a total of 45 seconds per step. The data shows that A.S.A.P. Polishers produced a higher gloss result after 30 seconds, than Enhance and PoGo did after 90-seconds.”

with

**Nate Lawson, DMD, MA, PhD**

**POLISHES MOST SUBSTRATES**

“Regardless of your chosen restorative material, creating a natural luster is key to a successful restorative result. The A.S.A.P. 2-step polishing system quickly mimics this natural reflective surface on all composites, zirconia, lithium disilicate, and most ceramics simply by using light pressure and a wiping motion for 15–20 seconds per polisher.”

with

**Megan Shelton, DMD**
Ask the Expert: An Interview with Dean Vafiadis, DDS on Adjusting and Polishing Zirconia Restorations

Dr. Dean Vafiadis received his dental degree and Prosthodontic specialty training at New York University College of Dentistry. He is the Director of the Full-Mouth Rehabilitation CE course at NYU and is an Associate Professor of Prosthodontics at NYU College of Dentistry. Dr. Vafiadis publishes and lectures on various topics such as aesthetics, implant designs, computer restorations, ceramic materials and occlusion. He is the founder of New York Smile Institute in NY, an educational center, full-service laboratory and learning facility as well as a private practice location for a multi-specialty practice for Implant and Aesthetic Dentistry. Dr. Vafiadis’ primary professional mission is to educate, publish, and invent new technologies that will help change the dental profession and patient’s lives. He is a member of the ACP, AAED, AO, AAID, ICOI, AACD and the ADA.

Q How are you currently polishing your zirconia restorations post-adjustment?
A I have always used a red-stripe or fine diamond bur to adjust my ceramic and zirconia restorations; however, it has been a big challenge to find a polishing system to remove the bur marks left on the restoration and reproduce the lab-like luster. Up until now, I couldn’t find a polishing system to do this. I still use a fine diamond for my contact and re-contouring adjustments but now use the A.S.A.P. Indirect+ Polishing System (Clinician’s Choice) to bring the adjusted surface back to a high gloss. It is a fast and simplified 2-step polishing system that brings the modified zirconia surface back to its high gloss. A.S.A.P. Indirect+ can be used both intra-orally and extra-orally, pre- and post-cementation and is capable of minor adjustments when you use the coarse adjusters that come with the kit, but they are also very effective in removing the scratches left behind after adjustments made with the fine diamond bur.

Q How much chairtime does it typically take for you to make adjustments to your zirconia restorations?
A Adjusting zirconia is so much faster now. Evaluating and adjusting proximal contacts and occlusion has always been very straightforward. The time-consuming part was progressing through various polishing steps to get the high shine back to the adjusted surfaces. The A.S.A.P. Indirect+ system is a 2-step polishing system, but the kit includes coarse adjusters that I have incorporated into my polishing regimen to remove bur scratches. Now my adjustment/polishing of zirconia takes anywhere from 2–4 minutes, and the result is exactly what I want.

Q Are you finding A.S.A.P. Indirect+ Adjusters and Polishers durable during use as well as after multiple sterilizations?
A My experience with the A.S.A.P. Indirect+ system is that I do not need to replace any component very often at all. I am polishing at least 30 zirconia crowns before I have to replace these polishers as the polishers are wearing at a very slow rate and are not breaking down with the numerous sterilizations.

Q Can you take us through a typical zirconia restoration chairside adjustment?
A Whether it is a proximal contact or occlusal interference, I use a fine diamond bur in a high-speed handpiece to make the adjustment extra-orally, maintaining a speed at about 20,000 RPMs. (FIG. 1) Once I am satisfied with the modification, I use the disc-shaped gray adjuster from the A.S.A.P. Indirect+ kit to remove the scratches left from the diamond bur. I use light pressure with this for 10 seconds and without water. (FIG.2–3) The blue pre-polisher is applied with relatively heavy pressure for about 20 seconds, followed by the pink final polisher with light pressure (without water spray) for 10 seconds at approximately 1,700 RPMs. (FIG. 4–5) I follow these zirconia adjustments with a wet Robinson brush over the adjusted surface.

Dean Vafiadis DDS

Dr. Vafiadis publishes and lectures on various topics such as aesthetics, implant designs, computer restorations, ceramic materials and occlusion.
Recognized for 5 years in a row by Dental Advisor, the A.S.A.P.® Indirect+ diamond polishing system is all you need to refine and create an outstanding shine on all your zirconia and ceramic restorations.

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(791-0640)
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